Commonwealth of Massachusetts
Executive Office of Health and Human Services

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Health Safety Net Office Companion Guide for
Health-Care Claims
For ASC X12N 837 (version 4010A1)
For Health Safety Net Providers in the Acute Inpatient and/or Outpatient Setting

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1.0 Introduction

1.1 What Is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 — Administrative Simplification (HIPAA-AS) among other things, created a set of electronic data interchange standards for health care as established by the Secretary of Health and Human Services (HHS). HHS has adopted an Implementation Guide for each standard transaction. Version 0004010X096A1 of the 837 Institutional transactions is the standard established by HHS for institutional claims submission.

1.2 Purpose of the Implementation Guide

The Implementation Guide for the 837I claim transaction specifies in detail the required formats for claims submitted electronically. The implementation guide contains requirements for use of specific segments and specific data elements within the segments, and was written for all health-care providers and other submitters. It is critical that your software vendor or IT staff review this document carefully and follow its requirements to submit HIPAA-compliant files to HSNO.

1.3 How to Obtain Copies of the Implementation Guides

The 837I Implementation Guide for X12N 837 version 4010A1 and all other HIPAA standard transactions are available electronically at www.wpc-edi.com/HIPAA. HSNO Specific Implementation Guides for each claim type are available for download through Sends/iNet.

1.4 Purpose of This Companion Guide

This 837 Companion Guide was created for HSNO trading partners by HSNO to supplement the 837 Implementation Guide. It contains HSNO-specific instructions for the following:

- Data content, codes, business rules, and characteristics of the 837 transaction;
- Technical requirements and transmission options; and
- Information on testing procedures that each trading partner must complete before submitting 837 claims.

The information in this guide supersedes all previous communications from HSNO about this electronic transaction. The following policies are in addition to those being outlined in the HSNO provider manual for individual claim types. These policies in no way supersede HSNO regulations.

The 837I Implementation Specifications are only the elements that HSNO requires, when appropriate. Providers may submit additional loops and segments beyond the specification without any implications.

1.5 Intended Audience

The intended audience for this document is the technical staff responsible for submitting electronic 837 claims to HSNO. In addition, this information should be shared with the provider's Registration Department, Medical Records and Billing Office to ensure that all required billing information is available for claim submission.

2.0 Establishing Connectivity with HSNO

HSNO currently uses Sends/iNet to act as the gateway between provider and adjudicator.

2.1 Setup

All HSNO trading partners must sign a Trading Partner Agreement (TPA) and will be requested to complete a trading partner profile (TPP) form before submitting electronic 837 transactions. Note that TPP information may be given over the telephone in lieu of completing a paper form. If you have already completed these forms, you do not have to complete them again. Please contact HSNO Help Desk at 1-800-609-7232 if you have any questions about these forms.

HSNO trading partners must submit HIPAA 837 claims to HSNO via the Sends/iNet process. All test files submitted through iNet require that the provider select the 837 Test option, otherwise the file will be treated as Production.

After establishing a transmission method, each trading partner must successfully complete testing. Information on this phase is provided in the next section of this companion guide (see Section 2.2: Trading Partner Testing). After successful completion of testing, 837 transactions may be submitted for production processing.

All test files should also have these following elements:
ISA15 = T (Test)
GS08 = 004010X96A1
REF02 = 004010X96DA1

Hard media will not be accepted.

2.2 Trading Partner Testing

Before submitting live 837 claims to HSNO, each trading partner must be tested. All trading partners who plan to submit 837 transactions must contact HSNO Help Desk at 1-800-609-7232 in advance to discuss the testing process, criteria, and schedule.

Trading partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional, and mutually defined components of the transaction. If you are a first-time submitter:
• We require a file with a minimum of 10 and a maximum of 50 test claims.
• The patient and provider data must be valid for a mutually agreed upon effective date.

The following conditions must be addressed in one or more test files:
The test files should contain as many types of claims as necessary to cover each of your business scenarios.
• Original claims;
• Void claims (if you plan to submit void claims; last digit of Type of Bill should be 8);
• Replacement claims (if you plan to submit void transactions and replacement claims; last digit of type of Bill should be 7); and
• Coordination of benefits claims (COB, if you plan to submit COB claims).

Providers submitting test files containing COB claims (where the patient has other insurance) should include a minimum of 10 and a maximum of 50 COB claims with the following criteria:

• Claims with commercial insurance (denied/paid);
• Claims with Medicare (denied/paid);
• Claims with Medicaid (denied/paid);

• Claims with multiple insurance, if applicable; and

All test files, regardless of the type of services provided, should be submitted using the naming convention as supplied by the SENDS software. Do not alter the file name, as this will cause submission errors

HSNO will process these transactions in a test environment to validate that the file structure and content meet HIPAA standards and HSNO-specific data requirements. Once this validation is complete, the trading partner may submit production 837 transactions to HSNO for adjudication. **Test claims will not be adjudicated.**

2.3 Technical Requirements

There is no current maximum file size for any 837 file submitted to HSNO. However it is recommended during the Testing phase to limit the size per upload. If you are uploading multiple 837 files using the transactions site, the maximum is sixteen megabytes per upload, not per file. HSNO endorses the ASC recommendation that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5,000 CLM segments. **There can only be one instance of an ST-SE transaction within a GS-GE or ISA-IEA.**

2.4 Acknowledgements

Confirmation numbers are generated for all 837 transaction files uploaded to the Web portal, indicating file upload status. 837 files submitted to HSNO that fail syntactical accuracy will produce a TA1 interchange acknowledgement only. 837 files submitted to HSNO that pass interchange acknowledgements will produce a 997 file acknowledgement. These acknowledgements will be available for download from the transactions Web site.

HSNO uses the tilde (~) segment terminator on all outbound HIPAA-compliant transactions. HIPAA-compliant outbound transactions from HSNO include the 835 electronic remittance advice transactions and the 997 acknowledgements.

2.5 Support Contact Information

Health Safety Net Office Help Desk
Phone: 1-800-609-7232

3.0 Health Safety Net Office-Specific Submission Requirements

The following information is for production claims. For test claims refer to the Trading Partner Testing section.

The following sections outline recommendations, instructions, and conditional data requirements for 837 claims submitted to HSNO. This information is designed to help trading partners construct the 837 transactions in a manner that will allow HSNO to efficiently process claims.

3.1 Claims Attachments

HSNO does not accept electronic Claims Attachments.

Should HSNO require additional documentation to process a claim, that claim will be suspended for 30 days to allow for a submission period of supporting documentation. Claims that were suspended and were not matched to submitted documentation within 30 days will process as denied.

Periodically, HSNO may ask providers to verify the completion of attachments kept on file. In cases where HSNO reviews have revealed provider noncompliance with the recordkeeping requirements

Medical Hardship claims require hard-copy documentation to be submitted into the Division prior to the Claim being submitted for processing. Please review 114.6 CMR 13.05 (1-7) for Application process and Claim submission requirements.

3.2 Encounter Claims

HSNO does not accept encounter claims. For further details, see Section 3.6: Detail Data

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3.3 Coordination of Benefits (COB)

The implementation of the 837 transaction enables providers to submit claims for patients with other insurance electronically to HSNO, after billing all other resources. Claims where HSNO is the secondary payer or the patient has Medicare supplemental insurance must be submitted to HSNO by the provider. Providers must submit claims adjudicated by Medicare to HSNO because there is no agreement between HSNO and the Medicare fiscal intermediary or carrier. When submitting an 837 transaction to HSNO for patients with other insurance, providers must supply the other payer's adjudication details that were provided on the 835 remittance transaction along with the Health Care Finance & Policy Payer ID. Providers are required to enter the other payer's adjudication details at the claim level. The adjustment reason codes entered in the COB loops should be the exact codes given by the other payer. Altering the adjudication details given by the other payer is considered fraudulent.

In addition, HSNO requires providers to enter the assigned carrier code on the 837 transaction to identify the other insurance.

After billing all resources before billing HSNO, enter the first three digits of the other payer's carrier code on the 837 transaction.

3.3.1 COB Bundled Claims

HSNO will process claims for services that are bundled by a commercial insurance or Medicare as a bundled claim.

3.4 Void and Replacement Transactions

Please Note: Under HIPAA guidelines, adjustments to paid claims should be submitted as a void or a replacement transaction.

Void transactions are used by submitters to correct and report any one of the following situations:

- Duplicate claim erroneously paid;
- Acknowledgment / Payment to the wrong provider;
- Acknowledgment / Payment for the wrong patient;
- Acknowledgment / Payment for services for which payment was received from third-party payers after HSNO processing of claim

Replacement transactions are used by submitters to correct and report any one of the following situations:

- To add Late Charges to a claim
- To remove Charges from a claim
- To correct any component of a claim (subscriber/patient demographics as well)

3.5 Production File-Naming Convention

837I files, regardless of the type of services provided, should be submitted using the naming convention as supplied by the SENDS software. Do not alter the file name, as this will cause submission errors

All Production files must have these following elements:
ISA15 = P (Production)
GS08 = 004010X96A1
REF02 = 004010X96A1

Hard media will not be accepted (e.g., paper claims, magnetic media).

3.6 Detail Data

HSNO recommends that submitters pay special attention to the following segments as these segments have already generated questions. Some of these are required segments and others are situational or optional, please see the 837I Implementation Specification document to see the required segments.

CHANGES since the last posting are high-lighted in YELLOW.

Loop	Segment		Element Name	Companion Information
----	ISA	05	Interchange Sender ID Qualifier	Enter ”ZZ.”
----	ISA	06	Interchange Sender ID	Enter Provider HSNO Organization ID This will be treated as the Pay-To identifier by HSNO.
----	ISA	07	Interchange Receiver ID Qualifier	Enter ”ZZ.”
----	ISA	08	Interchange Receiver ID	Enter ”HSN3644”

Loop	Segment		Element Name	Companion Information
----	ISA	15	Interchange Usage Indicator	This element is used to indicate whether the transmission is in a test or production mode. A “P” indicates production data, and a “T” indicates test data.
----	GS	02	Application Sender’s Code	Enter Provider HSNO Organization ID
----	GS	03	Application Receiver's Code	Enter “HSN3644”
----	BHT	02	Transaction Set Purpose Code	When submitting the 837 batch for the first time this code must equal 00 (Original). If resubmitting the file due to an issue like disrupted transmission, this code must equal 18 (Reissue).
----	BHT	06	Transaction Type Code	In the Beginning of Hierarchical Transaction (BHT) loop, BHT06 should always be equal to "CH," and all submitted 837 transactions should be claims for payment. A set of encounters, indicated by BHT06 equal to "RP," will pass compliance checks but no transactions within the set will be released to the adjudication system.
1000A	NM1	09	Submitter Identification Code	Submitter’s Organization ID Number. This will be used as the Pay-To Organization ID Number.
1000B	NM1	09	Receiver Identification Code	Enter ”HSN3644”
2000B	SBR	03	Reference Identification	DO NOT USE
2000B	SBR	04	Name of Destination Plan	Enter one of six HSNO Types: Prime, Second, Partial, BD, CA or MH. Prime = When HSN is the only payer Second = When HSN is secondary to any other payer (includes when Primary payer denies) Partial = When HSN is accepting the claim based upon Federal Poverty Level of the patient BD = ER Bad Debt Claim CA = Confidential Application Claim MH = Medical Hardship Claim
2000B	SBR	09	Subscriber Information Claim Filing Indicator Code	Enter ”ZZ” for HSNO Types = Prime, Second, or Partial Enter “09” for HSNO Types = BD, CA or MH

Loop	Segment		Element Name	Companion Information
2010BA	NM	108	Identification Code Qualifier	Enter “MI” for Member Identification Number
2010BA	NM	109	Identification Code	Enter the MassHealth Recipient ID Number if available Utilize when SBR02 = 18 (Self)
2010BA	REF	01	Subscriber Identification Code Qualifier	Enter “SY” for Social Security or Individual Tax ID ember ID Number. HSNO utilizes Social Security Number or Individual Tax Identification Number as the member identification.
2010BA	REF	02	Identification Code	Enter the Subscriber’s Social Security Number or Individual Tax Identification Number. When there is no SSN or TIN to submit enter “000000001”.
2010BC	NM1	08	Payer Identification Code Qualifier	Enter “PI”
2010BC	NM1	09	Payer Identification Code	Enter “995” for HSNO Payer ID
2000C	HL	02	Hierarchical Parent ID Number	Data element changed from “Not Required” to “Required”
2010CA	NM	108	Identification Code Qualifier	Enter “MI” for Member Identification Number
2010CA	NM	109	Identification Code	Enter the MassHealth Recipient ID Number if available Utilize when SBR02 is not reported
2010CA	REF	01	Patient Secondary Reference Identification Qualifier	Enter “SY” for Social Security or Individual Tax ID ember ID Number. HSNO utilizes Social Security Number or Individual Tax Identification Number as the member identification.
2010CA	REF	02	Patient Secondary Reference Identification	Enter the Subscriber’s Social Security Number or Individual Tax Identification Number. When there is no SSN or TIN to submit enter “000000001”.
2010CA	DMG	01	Date Time Period Format	Enter ‘D8’ for date formatted as CCYYMMDD
2010CA	DMG	02	Date Time Period (Patient’s Birth-date)	The patient’s birth date is a requirement for processing.
2010CA	DMG	03	Gender Code	Only one of three codes are allowed and is required: F = Female; M = Male; U = Unknown

Loop	Segment		Element Name	Companion Information
2300			Claim Information	The restriction of 100 claims has been removed. There is no limit to the number of claims submitted at this time.
2300	CL1	03	Patient Status Code	Required for all inpatient claims.
2300	CLM	05-1	Claim Information Facility Code Value (Facility Type Code)	The 837 format uses the first two characters of Bill Type to establish place of service for the entire claim. Only Bill Types of 11x and 13x are permitted for HSN billing purposes.
2300	CLM	05-3	Claim Frequency Type Code	The HSN will only accept Claim Frequency types of 1 = Original Claim 7 = Replacement of Prior Claim 8 = Void of Prior Claim Frequency Type 5 is not allowed. Submitters are not required to submit a Void claim first in order to submit a Replacement claim.
2300	CLM	18	Yes/No Condition or Response Code	Enter “Y” for EOB requested by Submitter
2300	DTP	01	Admission Hour	**This is required for Acute Inpatient Hospitals**. Enter the hour the patient was admitted for care.
2300	AMT	01/02	Patient Estimated Amount Due	If there is a patient paid amount associated with the services provided, enter ”F3” in REF01 and the amount of the patient paid amount in REF02.
2300	REF	01/02	Prior Authorization or Referral Number	HSNO does not provide Prior Authorization or Referral Numbers at this time. However, if billing HSNO as Secondary to another insurance that had a Prior Authorization or Referral Number, that information must be on the claim.
2300	HI		DRG Information (Identifier DR)	This is not a required loop, removed from specification. If a submitter reports this information it will be allowed but not edited.
2300	HI		Occurrence Span Information (Identifier BI)	This is not a required loop, removed from specification. If a submitter reports this information it will be allowed but not edited.

Loop	Segment		Element Name	Companion Information
2300	HI	01-2	Occurrence Information Industry Code (Identifier BH)	REQUIRED FOR ER BAD DEBT CLAIMS. Submitters of ER Bad Debt Claims are required to file an Occurrence Code for the Write-Off Date of the claim. The Occurrence Code is equal to the Effective Date utilized by the National Uniform Billing Committee. This can be A2, B2 or C2 dependent upon where HSN is identified as the destination payer on the claim.
2300	HI	01-2	Value Information Industry Code (Identifier BE)	REQUIRED FOR ER BAD DEBT CLAIMS. Submitters of ER Bad Debt Claims are required to file an Value Code for the Write-Off Amount of the claim. The Value Code is equal to the Estimated Responsibility Code utilized by the National Uniform Billing Committee. This can be A3, B3 or C3 dependent upon where HSN is identified as the destination payer on the claim.
2310A	NM1	08	Attending Physician Identification Code Qualifier	Enter “XX” for National Provider Identification Number
2310A	NM1	09	Attending Physician Identification Code	Enter the Attending the Physician’s National Provider Identification Number
2310A	REF	01	Attending Physician Reference Identification Qualifier	Enter “0B” for Board of Registry in Medicine Number
2310A	REF	02	Attending Physician Reference Identification	Enter the Attending Physician’s BORIM Number **Required**
2310B	NM1	08	Operating Physician Identification Code Qualifier	Enter “XX” for National Provider Identification Number
2310B	NM1	09	Operating Physician Identification Code	Enter the Operating the Physician’s National Provider Identification Number
2310B	REF	01	Operating Physician Reference Identification Qualifier	Enter “0B” for Board of Registry in Medicine Number
2310B	REF	02	Operating Physician Reference Identification	Enter the Operating Physician’s BORIM Number **Required**

Loop	Segment		Element Name	Companion Information
2310C	NM1	08	Other Provider Identification Code Qualifier	Enter “XX” for National Provider Identification Number
2310C	NM1	09	Other Provider Identification Code	Enter the Other Provider’s National Provider Identification Number
2310C	REF	01	Other Provider Reference Identification Qualifier	Enter “0B” for License Number
2310C	REF	02	Other Provider Reference Identification	Enter the Other Provider’s BORIM Number or other license number for non-physician medical professional (midwife, CRNA, therapist) **Required**
2310E	NM1	08	Service Facility Identification Code Qualifier	Enter “XX” for National Provider Identification Number
2310E	NM1	09	Service Facility Identification Code	Enter the National Provider Identification Number of the Service Facility
2310E	REF	01	Service Facility Reference Identification Qualifier	Enter “LU” for Location Number **Required**
2310E	REF	02	Service Facility Reference Identification	Enter the Organization ID Number of the Service Facility **Required**
2330A	REF	01	Other Subscriber Reference Identification Qualifier\	Enter “SY”. HSNO utilizes Social Security Number or Individual Tax Identification Number as the member identification.
2330A	REF	02	Other Subscriber Reference Identification	Enter the Subscriber’s Social Security Number or Individual Tax Identification Number. When there is no SSN or TIN to submit enter “000000001”.
2330B	NM1	08	Other Payer Name Identification Code Qualifier	Enter “PI” for Payer Identification
2330B	NM1	09	Other Payer Name Identification Code	Enter the EDI Payer ID number if applicable This is a pre-existing list.
2330B	REF	01	Other Payer Reference Identification Qualifier	Enter “2U” for Payer Identification Number
2330B	REF	02	Other Payer Reference Identification	Enter the DHCFP Payer ID Number This is a pre-existing list
2330C	REF	01	Other Payer Patient Reference Identification Qualifier	Enter “SY”. HSNO utilizes Social Security Number or Individual Tax Identification Number as the member identification.

Loop	Segment		Element Name	Companion Information
2330C	REF	02	Other Payer Patient Reference Identification	Enter the Subscriber's Social Security Number or Individual Tax Identification Number. When there is no SSN or TIN to submit enter "000000001".
2400	SV2	02-3, 02-4, 02-5, 02-6	Procedure Modifier	Modifiers are situational by use. If the Service Line is required to have a modifier, then the modifier must be present in order to pass edits in the Grouper. Only modifiers accepted by Medicare will be processed.
2400	DTP	01, 02	Service Line Date	User Option changed from Required to Situational as this is an Outpatient or reporting necessary drug administration dates on Inpatient claims.

3.7 Detail Data for COB Claims

Loop	Segment		Element	Companion Information
2330B	NM1	08	Identification Code Qualifier	Enter "PI" for payer identification.
2330B	NM1	09	Other Payer Primary Identifier Code	Enter one of the Health Care Finance & Policy Payer ID when NM108 is "PI"

3.7.1 COB Crosswalk

Data Element Name	Destination Payer Location Loop | Segment	Other Payer Location Loop | Segment Element
Subscriber Last Name	2010BA | NM103	2330A | NM103
Subscriber First Name	2010BA | NM104	2330A | NM104
Subscriber Middle Name	2010BA | NM105	2330A | NM105
Subscriber Suffix	2010BA | NM107	2330A | NM107
Subscriber Identification Number	2010BA | NM108 / NM109	2330A | NM108 / NM109
Subscriber Street Address 1	2010BA | N301	2330A | N301
Subscriber Street Address 2	2010BA | N302	2330A | N302
Subscriber City	2010BA | N401	2330A | N401
Subscriber State	2010BA | N402	2330A | N402
Subscriber ZIP Code	2010BA | N403	2330A | N403
Payer Name	2010BC | NM103	2330B | NM103
Payer ID	2010BC | NM108 / NM109	2330B | NM108 / NM109
Patient Identification Number	2010CA | NM108 / NM109	2330C | NM108 / NM109
Relationship of Subscriber to Patient	2000B | SBR02	2320 | SBR02
Assignment of Benefits Indicator	2300 | CLM08	2320 | OI03
Patient's Signature Source Code	2300 | CLM10	2320 | OI04
Release of Information	2300 | CLM09	2320 | OI06
Prior Authorization / Referral Number **(Claim Level)**	2300 | REF01 / REF02	2330C | REF01 / REF02 of Prior Authorization / Referral Number REF.
Provider Identification Number(s) **(Claim Level)**	2310A-E | REF01 / REF02	2330D-H | REF01 / REF02 of other Payer Provider Identifiers / Not Required
Payer Specific Amounts	No Elements	All AMTs in the 2320 loop are specific to the payer identified in the 2330B loop of that iteration of the 2320 loop.

3.8 Additional Information

HSNO does not process certain loops that do not apply to the HSNO business model. For example, HSNO does not process *2010BB Credit/Debit Card Account Holder Name* since HSNO is not a Payment Processor. In certain circumstances, these loops may be required in a compliant 837 transaction. However, the data content of these loops will not affect the HSNO claims adjudication process.

3.9 Service Codes

Please consult the AMA and NUBC reference publications for information on acceptable revenue, procedure and service codes. This information is also available on the Web.

HSNO will continue to use the same Payer Codes as previously established.

4.0 Version Table

Version	Date	Section/Pages	Description
1.0	**6/21/07**	**Entire Document**	**Document is a mimic of the MassHealth Companion Guide with changes for HSNO**
1.1	**8/16/07**	**Detail Data**	**ISA06, GS02, Loop1000A NM109, Loop2010AA REF01 updated to take NPI numbers only. Removed ORG ID and Medicare Provider Number references from these elements. Loop2010AB REF01 updated to take Org ID number.**
1.2	**8/24/07**	**Appendices**	**Appendix D added to incorporate UB92 to 837 crosswalk**
1.2	**8/27/07**	**Detail Data**	**ORG ID and National Provider IDs re-mapped based upon provider feedback. Legacy Medicare Provider numbers are no longer required.**
1.2	**8/30/07**	**Sample Transaction**	**Section 4 Removed**
2.0	**9/21/07**	**Version Table**	**Section 5 renumbered to 4**
2.0	**9/27/07**	**Detail Data**	**Removed Loops 2010AA, 2010AB. Removed requirement to submit Loop2010BC segments N3, N4 and REF.**
2.0	**9/29/07**	**Entire Document**	**All HSNO Providers are to submit their Professional Charges on the 837I utilizing the appropriate Revenue Code category for services performed/billed.**
2.0	**9/29/07**	**Entire Document**	**All HSNO Providers are to submit their Dental Charges on the 837I utilizing the appropriate Dental HCPCS and Revenue Code category for services rendered/delivered.**
2.0	**10/1/07**	**Technical Requirements**	**Only one instance of an ST-SE may be submitted within the GS-GE/ISA-IEA.**
2.0	**10/2/07**	**Trading Partner Testing**	**Reworded to incorporate SENDS encryption process**
2.0	**10/2/07**	**Production File Naming Convention**	**Reworded to incorporate SENDS encryption process**
2.0	**10/4/07**	**COB Crosswalk**	**This table was added to aid providers with data elements for submitting Secondary Claims.**
2.1	**12/01/07**	**FAQs**	**Q&A's added to the current list.**
2.1	**12/14/07**	**Detail Data**	**Highlighted loops and/or segments edited to reflect changes**
2.1a	**12/19/07**	**Detail Data**	**2330B NM109 and 2330B REF02 information updated**

Appendix A: Frequently Asked Questions

Q: How can I receive 997 functional acknowledgements for rejects at the claim level rather than the transaction-set level?
A: The 997 acknowledges rejection of all claims within the ST/SE boundary. The only way to receive a 997 rejection for each invalid claim is to submit your 837s with only one claim per transaction set.

Q: Can providers use a third-party vendor to perform claims submissions for them?
A: Providers can use a third-party vendor to submit their claims files. The vendors need to follow the same sign-up procedure that the provider used in order to gain access to SENDS/iNet. It is recommended that the Provider obtain the SENDS/iNet agreements and fill them out for their vendor, have them signed and then submitted into the Division of Health Care Finance & Policy for log-on creation.

Q: When applicable, should I use the place-of-service codes contained in the HIPAA Implementation Guide when submitting HSNO paper claim forms too?
A: HSNO does not accept paper claims; please call the HSNO Help Desk 1-800-609-7232

Q: What are the characters used to separate the various elements within the 837?
A: The HSN is using the asterisk (*) to separate data elements within segment and the tilde (~) as the segment terminator. Each segment must be followed by a carriage return line feed so that the elements are not bundled together.

Q: HSNO has allowed outpatient departments that perform dental procedures to use the CDT codes and the CPT codes for oral surgery services. The 837D Implementation Guide states that CDT codes are the only service codes allowed when filing an electronic claim. What is the process for an outpatient department to submit claims for oral surgery services using a CPT code?
A: HSNO requires that any and all services performed in the Acute Inpatient and/or Outpatient setting be included in the 837I claim for the patient. This includes Dental and Professional Services.

Q: How does a provider report Professional and/or Dental services on the 837I?
A: Providers should use the Professional Revenue Code ranges developed by the National Uniform Billing Committee of 096x, 097x and 098x to report specific Professional services, if they are billing them. All Dental HCPCS are to be reported using Revenue Code 512.

Q: Why does HSNO require both NPI and BORIM numbers for any Physician appearing on a claim? Isn't the NPI enough information to identify the provider?
A: The BORIM number requirement is in place due to the complexity of the way providers applied for NPIs. The BORIM number identifies the actual provider of service to HSNO where, depending on how the NPI was filed may not provide the person vs. non-person entity identification.

Q: How can a provider submit a claim with a Social Security or Individual Tax Identification Number requirement if the patient is an Undocumented Patient?
A: Providers are allowed to utilize the following number (a dummy number) if the patient has neither a Social Security nor Individual Tax Identification Number: 000000001.

Q: How will HSNO determine Eligibility if I submit claims with 000000001 and there is a name mismatch with REVS?
A: Providers are encouraged to report the MassHealth Recipient ID Number in the Patient NM109 element. When 000000001 appears, the system will look for the MassHealth RID Number in this element to continue its Eligibility match.

Q: If I identify other insurance that is not on file with HSNO, how do I submit the claim?
A: Follow the standard process for any coordination of benefits (COB) claim. To obtain the Division's assigned carrier code, cross reference the insurance name with the appropriate carrier code and enter the first three digits of the code on your 837 transaction. Concurrently, you should request that the HSNO Payer ID file be updated by speaking with a HSNO Help Desk representative at 1-800-609-7232

Q: Does HSNO want their Payer Codes or the National Plan ID codes when submitting Secondary Claims?
A: HSNO requires that the Providers submit the Health Care Finance & Policy Payer IDs at this time.

Q: Does the current 837I have a claim volume limitation of 100 like other payers?
A: The HSN does not require that a limitation be placed on the number of claims within the ST/SE envelope. However the file must have at least one claim in order to be processed.

Q: We currently submit a monthly file to UCP. Can the providers continue with this schedule?
A: HSN Claim submission scheduling is a business decision that needs to be determined by the provider. However, with the new regulations in regards to timely filing and the ability to post denials into provider collections systems via the 835, providers are encouraged to submit on a weekly basis. This will allow denied claims to be posted, reviewed for resubmission and re-submitted in a timely manner.

Q: Do providers still report Value Code PE when submitting ER Bad Debt Claims?
A: Providers are not to use the PE Value Code for HSN Claims. The claim must have the HSN type of BD identified in the Subscriber loop of the 837I. Then apply Occurrence Code A2, B2 or C2 (dependent on the line HSN is the Destination Payer on the claim) and the date of write-off. The claim must also have a Value Code of A3, B3 or C3 (to match Occurrence Code) with the amount written-off to Bad Debt.

Q: What about Value Code PF for Free Care claims?
A: The HSN does not use this code to identify these claims. The HSN Type options of Prime, Second and Partial are to be used now and reported in the Subscriber loop of the 837I. This in addition to the Amount fields used in the 837I, allow the HSN to obtain the appropriate values.

Appendix B: Provider Types to Invoice Types Map

If you are this Provider Type….	and currently submit this type of claim…	and billing this allowable service…	Then use this HIPAA Transaction or Billing Function*.
Acute Outpatient Hospital	UCP UB92	Acute Outpatient Services, Physician Services, Dental Services, Psychiatric Services	837I
Acute Inpatient Hospital	UCP UB92	Acute Outpatient Services, Physician Services, Dental Services, Psychiatric Services	837I
Community Health Center	UCP MA-9	Medicine CPTs	837P
Community Health Center	UCP MA-9	Dental CDTs	837D
Pharmacy	UCP UB92	NCPDP	POPS

Appendix C: Links to Online HIPAA Resources

The following is a list of online resources that may be helpful.

Accredited Standards Committee (ASC X12)

• ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org

American Hospital Association Central Office on ICD-9-CM (AHA)

• This site is a resource for the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes used in medical transcription and billing and for Level I HCPCS. www.ahacentraloffice.org

American Medical Association (AMA)

• This site is a resource for the Current Procedural Terminology 4th Edition codes (CPT-4). The AMA copyrights the CPT codes. www.ama-assn.org

Association for Electronic Health-care Transactions (AFEHCT)

• AFEHCT is a health-care association dedicated to promoting the interchange of electronic health-care information. www.afehct.org

Centers for Medicare and Medicaid Services (CMS)

• CMS, formerly known as HCFA, is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Healthcare Transactions and Code Sets Model Compliance Plan at www.cms.hhs.gov/default.asp?fromhcfadotgov=true.

• This site is the resource for information related to the Healthcare Common Procedure Coding System (HCPCS). www.cms.hhs.gov/MedHCPCSGenInfo/

Designated Standard Maintenance Organizations (DSMO)

• This site is a resource for information about the standard-setting organizations and transaction change request system. www.hipaa-dsmo.org

Health Level Seven (HL7)

• HL7 is one of several ANSI-accredited Standards Development Organizations (SDO), and is responsible for clinical and administrative data standards. www.hl7.org

Health Safety Net Office

• The Health Safety Net Office Web site assists providers with HIPAA billing and policy questions, as well as provider enrollment support. http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/07/hsntf_rec_policies_fy2008.pdf

National Council of Prescription Drug Programs (NCPDP)

• The NCPDP is the standards and codes development organization for pharmacy.
www.ncpdp.org

National Uniform Billing Committee (NUBC)

• NUBC is affiliated with the American Hospital Association and develops standards for institutional claims.
www.nubc.org

National Uniform Claim Committee (NUCC)

• NUCC is affiliated with the American Medical Association. It develops and maintains a standardized data set for use by the non-institutional health-care organizations to transmit claims and encounter information. NUCC maintains the national provider taxonomy. www.nucc.org

Office for Civil Rights (OCR)

• OCR is the office within the Department of Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa

Sends / iNet

• The Sends/iNet process is a double-encrypted, secure method of transmitting health care information and data. Call 1-800-609-7232 to discuss how to load this software.

United States Department of Health and Human Services (DHHS)

• The DHHS Web site is a resource for the Notice of Proposed Rule Making, rules, and other information about HIPAA. www.aspe.hhs.gov/admnsimp

Washington Publishing Company (WPC)

• WPC is a resource for HIPAA-required transaction implementation guides and code sets. www.wpc-edi.com/HIPAA

Workgroup for Electronic Data Interchange (WEDI)

• WEDI is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org

Appendix D: UB92 Form Locator to 837 Element Crosswalk

The Crosswalk is included to help Providers identify the legacy Record Type and Field to the UB92 and/or UB04. The 837 Section is presented as a general guide as many Form Locators on either form are not required elements for the HSNO claims submission. Please see the 837I Implementation Specification v2.0 for corresponding Loops and Segments.